

# CERTIFICATE APPLICATION FOR: Theory, Knowledge and Practice about Autism Spectrum Disorders

NAME: \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS: \_\_\_\_\_  
STREET NAME AND NUMBER  
CITY STATE ZIP

EMAIL: \_\_\_\_\_

CELL PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**DO YOU HAVE A BACHELOR'S DEGREE?**  YES  NO

If you answered no, when will you graduate? \_\_\_\_\_

If you answered yes, please provide the following information:

UNIVERSITY NAME DEGREE DATE

TEACHING CREDENTIAL (if applicable) EXPIRATION DATE

**EMPLOYMENT INFORMATION** *Please attach a copy of your resume.*

POSITION: \_\_\_\_\_

SCHOOL DISTRICT: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

PRINCIPAL: \_\_\_\_\_

**PERSONAL STATEMENT** WHY WOULD YOU LIKE TO GET THIS CERTIFICATE?

Please submit all paperwork to the address provided above.